MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 12515

PLACE OF DEATH
County Clark
Township Union
or
Village
or
City (NO. St.; Ward)

Registration District No. 190 File No. ~~12120~~
Primary Registration District No. 3265 Registered No. 79

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Cyntha Hodges

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female
COLOR OR RACE: white
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widowed

DATE OF BIRTH: July (Month) 27 (Day), 1811 (Year)

AGE: 101 yrs. 8 mos. 14 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): — 0 — 0

BIRTHPLACE (City or town, State or foreign country): Kentucky

PARENTS
NAME OF FATHER: Robt. Creath
BIRTHPLACE OF FATHER (City or town, State or foreign country): Virginia
MAIDEN NAME OF MOTHER: Anna Crofford
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Hodges
(ADDRESS) Kahoka Mo

Filed April 11, 1913 W B Lisson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 11 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__, that I last saw her alive on Mar 9, 1913, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Old Disease Unknown

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) S. E. Dost M. D.
Apr 11th 1913 (Address) Wyaconda

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Neper Cemetery
DATE OF BURIAL: April 13 1912
UNDERTAKER: Fred Gerth
ADDRESS: Wyaconda Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County

MISSOURI STATE BOARD OF HEALT
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township SEP 23 1954 _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.: _____ Ward)

[If death occurred hospital or institut give its NAME ins of street and number

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day) _____, 1 _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day) _____, 191

I HEREBY CERTIFY, that I attended deceased f _____, 191__, to _____, 191

that I last saw h _____ alive on _____, 191

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____ M.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, st (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS

Revised Uni

[Approved by

Statement

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Statement

DISEASE CAUSIN
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